BHSF Newborn Request Form
Rev. 10/06
Prior Issue Obsolete

DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAID PROGRAM
Request for Newborn Medicaid ID Number

(Please Type or Print Legibly)

PART I (To be completed by Hospital)

Mother's Name _____ Mother's Medicaid No. _____
(13-digit Medicaid Person Number)

Date of Admission _____ Mother's D.O.B. _____ Soc. Sec. No. _____

Mailing Address _____ City _____ State _____ Zip Code _____

Parish of Residence _____ Phone (_____) _____

PART II (**To be completed after the child's birth**. Only enter information for providers that are able to bill Medicaid for the Newborn.)

Newborn's Name _____
First Name, Middle Initial (if applicable), Last Name

Newborn's Sex ☐ M ☐ F D.O.B. _____ Newborn's Race _____

Special Notes: ☐ Twin A ☐ Twin B ☐ NICU ☐ Adoption – Date of Mother's Discharge: _____

☐ Expired – Date of Death: _____ ☐ Other _____

☐ Corrected Copy (What is being corrected?): _____

Hospital Name _____ Phone (_____) _____ Fax (_____) _____

Address _____ City _____ State _____ Zip Code _____

Baby's Attending Physician _____ Phone (_____) _____ Fax (_____) _____

Address _____ City _____ State _____ Zip Code _____

Baby's Pediatrician _____ Phone (_____) _____ Fax (_____) _____

Address _____ City _____ State _____ Zip Code _____

Baby's Other Provider _____ Phone (_____) _____ Fax (_____) _____

Address _____ City _____ State _____ Zip Code _____

Baby's Other Provider _____ Phone (_____) _____ Fax (_____) _____

Address _____ City _____ State _____ Zip Code _____

Upon release from the hospital, will the newborn live with the mother? ☐ Yes ☐ No

Has an application been made for a Social Security Number? ☐ Yes ☐ No

Does the mother of the newborn have private health insurance coverage? ☐ Yes ☐ No

_____ (_____) _____ _____
Signature of Facility Representative | Phone Number | Date

PART III (To be completed by BHSF)

☐ **Newborn is Medicaid Eligible** ☐ **Newborn is NOT Medicaid Eligible**

Newborn's Medicaid Person Number _____

Effective Date of Eligibility _____

BHSF Representative Signature _____ Date _____

Phone (_____) _____